# APPENDIX A: FREE CARE APPLICATION FORMS

This section contains copies of all of the free care application forms: the free care application (DHCFP-FC1); the condensed free care application form (DHCFP-FC2); the medical hardship supplement (DHCFP-FC3); the family supplement (DHCFP-FC4); and the facility use only form, which must accompany every free care application.

The application forms are also available on the Division's Web site, as is this application guide. Translations of the application forms are posted as they become available.

# APPLICATION FOR FREE CARE

**If you need assistance filling out this application please contact:**

This form will be used to determine if you are eligible for Free Care or if you may qualify for health care coverage through other programs. If you are applying for someone else, please answer all questions using the applicant's information. If a section or question does not apply to you or any family member, write "N/A." If you need additional space, please use another sheet of paper.

## APPLICANT INFORMATION

**Last Name** | **First Name** | **MI**

**Social Security Number (SSN) or Tax I.D. Number (TIN)** *(if one has been issued)*

**Street Address**

**Telephone Numbers**
(Home) ( )
(Work) ( )

**City** | **State** | **Zip**

**Mailing Address** *(if different from street address)*

**Date of Birth**

**Are you homeless?** Yes ❑ No ❑

**Gender** Male ❑ Female ❑

**Are you pregnant?** Yes ❑ No ❑

**If you are applying for someone else, please complete this section as the contact person.**

**Last Name** | **First Name** | **MI**

**Relationship to Applicant:**

**Street Address**

**Telephone Numbers**
(Home) ( )
(Work) ( )

**City** | **State** | **Zip**

**Mailing Address** *(if different from street address)*

## FAMILY INFORMATION

Please list the people in your family that live with you. Include your **spouse** and any dependent **children under age 18** that either of you may have that live with you. If you are applying for a child under age 18, please include any brothers or sisters under 18 who live with the child, and the child's parent or parents who live with the child.

| Name of Family Member | SSN or TIN *(if one has been issued)* | Relationship | Date of Birth | Gender M F | Pregnant Y N |
|---|---|---|---|---|---|
| | | | | ❑ ❑ | ❑ ❑ |
| | | | | ❑ ❑ | ❑ ❑ |
| | | | | ❑ ❑ | ❑ ❑ |
| | | | | ❑ ❑ | ❑ ❑ |
| | | | | ❑ ❑ | ❑ ❑ |

## EARNED INCOME

Please complete this section about income (before taxes and deductions) for each family member who works.

| Name of Working Family Member | Amount Earned | How Often? | Facility Use Only *Total Income* |
|---|---|---|---|
| **Employer Name & Address** | | | |
| **Number of people who work for this employer: under 50 ❑ 51-200 ❑ over 200 ❑ Don't know ❑** | | | |

| Name of Working Family Member | Amount Earned | How Often? | Facility Use Only *Total Income* |
|---|---|---|---|
| **Employer Name & Address** | | | |
| **Number of people who work for this employer: under 50 ❑ 51-200 ❑ over 200 ❑ Don't know ❑** | | | |

## OTHER INCOME

Please complete this section about other income (before taxes and deductions) for each family member who receives other income. Other income is money you receive that does not come from an employer.

| Type of Income | Family Member(s) Receiving Income | Amount Received | How Often *(circle one)* | Facility Use Only *Total Income* |
|---|---|---|---|---|
| Social Security | | | Weekly, Monthly, Annually | |
| Railroad Retirement | | | Weekly, Monthly, Annually | |
| Veterans' Benefits | | | Weekly, Monthly, Annually | |
| Retirement Funds | | | Weekly, Monthly, Annually | |
| Annuities | | | Weekly, Monthly, Annually | |
| Pensions | | | Weekly, Monthly, Annually | |
| Child Support | | | Weekly, Monthly, Annually | |
| Alimony | | | Weekly, Monthly, Annually | |
| Unemployment | | | Weekly, Monthly, Annually | |
| Workers' Comp. | | | Weekly, Monthly, Annually | |
| Rental Income | | | Weekly, Monthly, Annually | |
| Trust Income | | | Weekly, Monthly, Annually | |
| Transitional Assistance | | | Weekly, Monthly, Annually | |
| EAEDC | | | Weekly, Monthly, Annually | |
| Dividend Income | | | Weekly, Monthly, Annually | |
| Bank Account Income | | | Weekly, Monthly, Annually | |
| Other | | | Weekly, Monthly, Annually | |

*If you or anyone listed on page 1 are **required** to make payments for alimony, child support, or a personal needs allowance for a family member in a nursing home, please fill out the section below.*

| Type of Payment | Recipient | Amount Paid | How Often *(circle one)* | Facility Use Only *Total Payment* |
|---|---|---|---|---|
| Alimony | | | Weekly, Monthly, Annually | |
| Child Support | | | Weekly, Monthly, Annually | |
| Personal Needs Allowance | | | Monthly | |

## OTHER INSURANCE

*If you have health insurance, you may still be eligible for Free Care to pay for amounts such as copayments and deductibles.*

1. Are you covered under any health insurance policy, including foreign coverage and Medicare? Yes ❑ No ❑
   **If yes, please provide the following information:**
   Policy Holder: _ Insurer: _ Policy Number:_____
   Policy Holder: _ Insurer: _ Policy Number:_____
2. Are you seeking Free Care because of a work-related accident or injury? Yes ❑ No ❑
3. Are you seeking Free Care because of a motor vehicle accident? Yes ❑ No ❑
4. Do you have a lawsuit or other insurance claim pending for coverage of this illness or injury? Yes ❑ No ❑
5. Are you a college student? Yes ☐ No ☐ If yes: Full time? ☐ Part time? ☐
6. Do you have an application pending for any of these programs? (*check all that apply*) Yes ❑ No ❑

   ☐ Children's Medical Security Plan ☐ MassHealth ☐ CenterCare

   ☐ Transitional Assistance ☐ Healthy Start ☐ EAEDC

   ☐ Other _____ ☐ Boston HealthNet ☐ Cambridge NetworkHealth
7. Are you currently approved for Free Care at another hospital or community health center? Yes ☐ No ☐
   **If yes:** Where?_____

## OPTIONAL QUESTION

*This question is asked for data collection and analysis purposes only and in no way will be used to determine Free Care eligibility.*

**Race**

☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ White, not Hispanic
☐ Black, not Hispanic ☐ Hispanic ☐ Other_____

## ASSIGNMENT OF RIGHTS

***Please read this section carefully and sign at the bottom.***

I authorize my employer and my health insurer to give to this hospital or community health center information about income, health insurance premiums, coinsurance, co-payments, deductibles, and covered benefits that I have.

If I am seeking Free Care because of an accident or other incident, and I receive money because of that accident or incident from any sources, such as workers' compensation or an insurance carrier, I will repay the hospital or community health center for any medical services paid by the Free Care Pool. I give this hospital or community health center the right to collect payments from insurers for medical care as appropriate.

While I am eligible for Free Care, I agree to tell this hospital or community health center of any changes in my family status including family size, income changes, and health insurance coverage which could change my eligibility for Free Care.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize this hospital or community health center to give to the Division of Health Care Finance and Policy or its designee the information needed to confirm my eligibility for Free Care and to administer the Free Care Pool. **I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any state or federal agency, except as stated above, without my prior approval.**

_____ _____
Signature of applicant Date

*If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.*

_____ _____
Signature of authorized representative Date

## Use This Page for Additional Information

# CONDENSED APPLICATION FOR FREE CARE

**If you need assistance filling out this application please contact:**

## APPLICANT INFORMATION

| Last Name | First Name | MI | Social Security Number (SSN) or Tax I.D. Number (TIN) *(if one has been issued)*: |
|---|---|---|---|
| | | | |
| **Street Address** | | | **Telephone Numbers**<br>(Home) ( )<br>(Work) ( ) |
| **City** | **State** | **Zip** | **Mailing Address** *(if different from street address)* |
| | | | |
| **Date of Birth** | **Are you homeless?**<br>Yes ❑ No ❑ | | |

**If you are applying for someone else, please complete this section as the contact person.**

| Last Name | First Name | MI | Relationship to Applicant: |
|---|---|---|---|
| | | | |
| **Street Address** | | | **Telephone Numbers**<br>(Home) ( )<br>(Work) ( ) |
| **City** | **State** | **Zip** | **Mailing Address** *(if different from street address)* |
| | | | |

## ASSIGNMENT OF RIGHTS

***Please read this section carefully and sign at the bottom.***

I authorize my employer and my health insurer to give to this hospital or community health center information about income, health insurance premiums, coinsurance, co-payments, deductibles, and covered benefits that I have.

If I am seeking Free Care because of an accident or other incident, and I receive money because of that accident or incident from any sources, such as workers' compensation or an insurance carrier, I will repay the hospital or community health center for any medical services paid by the Free Care Pool. I give this hospital or community health center the right to collect payments from insurers for medical care as appropriate.

While I am eligible for Free Care, I agree to tell this hospital or community health center of any changes in my family status including family size, income changes, and health insurance coverage which could change my eligibility for Free Care.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize this hospital or community health center to give to the Division of Health Care Finance and Policy or its designee the information needed to confirm my eligibility for Free Care and to administer the Free Care Pool. **I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any state or federal agency, except as stated above, without my prior approval.**

_____ _____

Signature of applicant Date

*If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.*

_____ _____

Signature of authorized representative Date

**APPLICATION FOR FREE CARE - MEDICAL HARDSHIP SUPPLEMENT**

**If you need assistance filling out this application please contact:**

This form will be used to see if you are eligible for Free Care under the category of Medical Hardship. In order to qualify for Medical Hardship, you must have previously applied for Free Care and provide information showing that your medical expenses are so high that you cannot pay your medical bills. The hospital will use the information in this supplement to determine if you qualify for Medical Hardship.

Please complete all sections of this supplement. If you are applying for someone else, please answer all questions using the applicant's information. If a section or question does not apply to you or any family member, write "N/A." If you need additional space, please use another sheet of paper.

**In Table 1,** list all of your medical expenses from all providers. Allowable medical bills include:

- unpaid bills for which you are still responsible, incurred either before or after you applied for Free Care; and
- bills paid after the date you applied for Free Care.

**In Table 2**, list all of your assets except for your primary residence (where you live) and one motor vehicle. List all other assets even if you own them with another person.

## APPLICANT INFORMATION

| **Last Name** | **First Name** | **MI** | **Social Security Number (SSN) or Tax I.D. Number (TIN)** *(if one has been issued)* |
|---|---|---|---|
| **Street Address** | | | **Telephone Numbers**<br>(Home) ( )<br>(Work) ( ) |
| **City** | **State** | **Zip** | **Mailing Address** *(if different from street address)* |
| **Date of Birth** | **Are you homeless?**<br>Yes ❑ No ❑ | | |

## TABLE 1: HEALTH EXPENSES

| Medical Expenses | Cost | How Often Does Cost Occur? |
|---|---|---|
| health insurance premium | | Weekly, Monthly, Annually |
| allowable medical bills | | Weekly, Monthly, Annually |
| Medicare Part A premium | | Weekly, Monthly, Annually |
| Medicare Part B premium | | Weekly, Monthly, Annually |

## TABLE 2: ASSET INFORMATION

*Do not include your primary residence (where you live) and one motor vehicle.*

| Asset | Owner(s) | Bank Name or Loan Holder | Account Number | Cash Value |
|---|---|---|---|---|
| cash | | | | |
| savings accounts | | | | |
| checking accounts | | | | |
| term certificates | | | | |
| trust accounts | | | | |
| credit union accounts | | | | |
| life insurance policies | | | | |
| real estate | | | | |
| individual retirement accounts (IRA) | | | | |
| Keogh plans | | | | |
| pension funds | | | | |
| annuities | | | | |
| boat | | | | |
| motor home | | | | |
| other vehicle(s) | | | | |
| stocks | | | | |
| bonds | | | | |
| futures contracts | | | | |
| money market accounts | | | | |
| mutual funds | | | | |
| promissory notes | | | | |
| other | | | | |

## SIGNATURE

***Please read this section carefully and sign at the bottom.***

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize this hospital or community health center to give to the Division of Health Care Finance and Policy or its designee the information needed to confirm my eligibility for Free Care and to administer the Free Care Pool. **I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any state or federal agency, except as stated above, without my prior approval.**

_____ _____

Signature of applicant Date

*If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.*

_____ _____

Signature of authorized representative Date

# APPLICATION FOR FREE CARE – FAMILY SUPPLEMENT

## APPLICANT INFORMATION

| Last Name | First Name | MI | **Social Security Number (SSN) or Tax I.D. Number (TIN)** *(if one has been issued)*: |
|---|---|---|---|
| **Street Address** | | | **Telephone Numbers** (Home) ( ) (Work) ( ) |
| **City** | **State** | **Zip** | **Mailing Address** *(if different from street address)* |
| **Date of Birth** | **Are you homeless?** Yes ❑ No ❑ | | |

**Family member whose Free Care application contains contact and income information for this applicant:**

| Last Name | First Name | MI | **SSN or TIN** *(if one has been issued)*: |
|---|---|---|---|
| | | | **Date of Birth:** |

**If you are applying for someone else, please complete this section as the contact person.**

| **Last Name** | **First Name** | **MI** | **Relationship to Applicant:** |
|---|---|---|---|
| | | | |

## OTHER INSURANCE

*If you have health insurance, you may still be eligible for Free Care to pay for amounts such as copayments and deductibles.*

1. Are you covered under any health insurance policy, including foreign coverage and Medicare? Yes ❑ No ❑
   **If yes, please provide the following information:**
   Policy Holder: _____ Insurer: _____ Policy Number:_____
   Policy Holder: _____ Insurer: _____ Policy Number:_____
2. Are you seeking Free Care because of a work-related accident or injury? Yes ❑ No ❑
3. Are you seeking Free Care because of a motor vehicle accident? Yes ❑ No ❑
4. Do you have a lawsuit or other insurance claim pending for coverage of this illness or injury? Yes ❑ No ❑
5. Are you a college student? Yes ☐ No ☐ If yes: Full time? ☐ Part time? ☐
6. Do you have an application pending for any of these programs? (*check all that apply*) Yes ❑ No ❑
   - ☐ Children's Medical Security Plan
   - ☐ MassHealth
   - ☐ CenterCare
   - ☐ Transitional Assistance
   - ☐ Healthy Start
   - ☐ EAEDC
   - ☐ Other _____
   - ☐ Boston HealthNet
   - ☐ Cambridge NetworkHealth
7. Are you or the original applicant currently approved for Free Care at another hospital or community health center? Yes ☐ No ☐
   **If yes:** Where? _____

## OPTIONAL QUESTION

*This question is asked for data collection and analysis purposes only and in no way will be used to determine Free Care eligibility.*

**Race**

- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ White, not Hispanic
- ☐ Black, not Hispanic
- ☐ Hispanic
- ☐ Other_____

## Assignment of Rights

***Please read this section carefully and sign at the bottom.***

I authorize my employer and my health insurer to give to this hospital or community health center information about income, health insurance premiums, coinsurance, co-payments, deductibles, and covered benefits that I have.

If I am seeking Free Care because of an accident or other incident, and I receive money because of that accident or incident from any sources, such as workers' compensation or an insurance carrier, I will repay the hospital or community health center for any medical services paid by the Free Care Pool. I give this hospital or community health center the right to collect payments from insurers for medical care as appropriate.

While I am eligible for Free Care, I agree to tell this hospital or community health center of any changes in my family status including family size, income changes, and health insurance coverage which could change my eligibility for Free Care.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize this hospital or community health center to give to the Division of Health Care Finance and Policy or its designee the information needed to confirm my eligibility for Free Care and to administer the Free Care Pool. **I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any state or federal agency, except as stated above, without my prior approval.**

_____ _____
Signature of applicant Date

*If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.*

_____ _____
Signature of authorized representative Date

# FACILITY USE ONLY

## Part I - General Information

Applicant name: _____ Date application received: _____

Medical record number: _____ Patient billing number: _____

## Part II - Eligibility and Verification of Documentation

Indicate documentation being used to verify patient residency: _____

Indicate documentation being used to verify reported income: _____

- ☐ Charge of $500 or less, no income documentation included. *If charges for this visit are $500 or less, verification of income is not required. This is limited to once per eligibility year.*

***Complete section A if using the Standard Free Care Application, or section B if using a Condensed Free Care Application. Complete sections A and C for Medical Hardship Applications.***

## Section A - Screening for Alternative Programs

Please explain why the patient is not enrolled in MassHealth:

- ☐ Income ineligible
- ☐ Characteristically ineligible *(see Section 4 of the application guide for an explanation of characteristically ineligible)*
- ☐ Applied but denied
- ☐ Declined to apply _____
- ☐ Asset ineligible (for patients over 65)
- ☐ Patient enrolled in MassHealth; service date prior to MassHealth eligibility/enrollment date

## Section B - Reason for Condensed Free Care Application

Indicate documentation being used to support completing a Condensed Free Care Application:

- ☐ Completed MBR *(may or may not have been submitted to MassHealth)*
- ☐ MBR submitted to MassHealth with proof that the service date for free care is prior to MassHealth enrollment/eligibility date
- ☐ CenterCare enrollment or waiting list status *(signature not required if FC checked on card)*
- ☐ CMSP enrollment
  - ☐ Full Free Care *($0 copay for preventive care/$1 copay for illness or injury)*
  - ☐ Partial Free Care *($0 copay for preventive care/$3 copay for illness or injury)*
- ☐ EAEDC enrollment *(signature not required)*
- ☐ Healthy Start enrollment
  - ☐ Full Free Care
  - ☐ Partial Free Care *(Healthy Start card marked with red star)*
- ☐ Completed full Free Care application and supporting documentation from another

hospital or community health center _____

*Name of Hospital or CHC*

## FACILITY USE ONLY (continued)

**Section C - Medical Hardship Documentation** *(if applicable)*

Indicate documentation being used to verify reported assets:

Asset Type: _____ Documentation: _____

Asset Type: _____ Documentation: _____

Asset Type: _____ Documentation: _____

Asset Type: _____ Documentation: _____

*(If you need additional space, please attach a separate sheet.)*

**Part III - Facility Approval**

***Type of Free Care***

☐ Full Free Care (<200% FPL)

☐ Partial Free Care (201-400% FPL)
*Deductible amount:* _____

☐ Medical Hardship
*Contribution amount:* .

☐ Denied

If using the Free Care application form as an application for Medicare Indigence:

☐ Medicare Indigence (*bill to Medicare, not to the Uncompensated Care Pool*)

***Free Care Eligibility Period***

Application Date: _____ Determination Date: _____

Eligibility Begin Date: _____ End Date: _____

*(Note: End date cannot be more than one year after begin date.)*

***Authorization***

Determination Made By: _____ Approved By: _____

Title: _____ Title: _____

# APPENDIX B: ACCEPTABLE DOCUMENTATION

## RESIDENCY VERIFICATION

| GROUP 1<br><br>**Preferred Documentation** | GROUP 2<br><br>**Acceptable Alternatives**<br><br>**(if these items do not contain a current address, they must be accompanied by either a piece of personal identification containing the person's current address or an affidavit signed by the applicant)** |
|---|---|
| **Driver's License**<br>**Utility Bill**<br>**Death Certificate**<br>**Unemployment Benefit Stub**<br>**State Income Tax Form**<br>**Federal Income Tax Form** | **Passport**<br>**Paycheck Stub**<br>**Student ID Card**<br>**Birth Certificate**<br>**Employee Identification**<br>**Social Security Card**<br>**Welfare or Insurance Plan Card**<br>**Travel Visa**<br>**Alien Registry Card**<br>**Voter ID Card** |

| **If the applicant cannot provide documentation from either of the above lists:** |
|---|
| The hospital or CHC shall document why the applicant was unable to provide documentation, and the applicant shall provide a signed affidavit that the applicant has resided in Massachusetts since the time of service, has no residency status in another state or country, and has the intent to remain in Massachusetts indefinitely. |

## INCOME VERIFICATION

| Income Type | Group 1: Preferred Documentation | Group 2: Acceptable Alternatives if the Applicant Cannot Comply with Group 1 | Acceptable Alternatives if the Applicant Cannot Comply with either Group 1 or Group 2 |
|---|---|---|---|
| Wages | recent paycheck stubs or pay envelopes from 2 prior weeks (or a longer time period if more reflective of the applicant's annual wages) | affidavit from the applicant's employer stating gross earnings from 2 prior weeks (or a longer time period if more reflective of the applicant's annual wages) | copy of signed contract *or* W-2 forms *or* most recent income tax return *or* an affidavit from the applicant of the applicant's wages |
| Self-employed income | tax returns and the 3 most current months' business records that show the total amount of income and business expenses associated with gross income earned | photocopy of most recent personal income tax (form 1040 or 1040A) | an affidavit from the applicant of personal income |
| Child support or alimony | court payment records *or* court order indicating payment amount | copies of canceled checks or money orders | |
| Personal Needs Allowance | affidavit from the applicant | | |
| Social Security, veteran's, unemployment, railroad retirement, workers' compensation, black | most recent benefit award letter *or* benefit statements *or* | | |

| | | | |
|---|---|---|---|
| lung, brown lung, and strikers benefits | check stubs | | |

## INCOME VERIFICATION (CONTINUED)

| Income Type | Group 1: Preferred Documentation | Group 2: Acceptable Alternatives if the Applicant Cannot Comply with Group 1 | Acceptable Alternatives if the Applicant Cannot Comply with either Group 1 or Group 2 |
|---|---|---|---|
| Income from investments, royalties, annuity payments | Statement from a financial institution, broker, investment firm, company or source of the royalty indicating the amount of interest, dividends, royalties paid or annuity payments, frequency of payment, and the amount paid in the year to date | most recent tax returns | |
| Retirement funds | retirement fund documents indicating the amount and frequency of payment | | |
| Pension | check stubs *or* retirement benefit letter | | |
| Rental income | lease *or* tax records *or* rental agency documents | copy of written agreement signed by both parties indicating the amount and frequency of payment | signed statement or receipt indicating the amount and frequency of payment |
| Life insurance proceeds | statement from the insurance carrier or agent | | |

| | | | |
|---|---|---|---|
| No income | affidavit explaining the applicant's financial situation | | |

## ASSET VERIFICATION

| Asset | Documentation |
|---|---|
| Cash | self declared |
| Savings and checking accounts, term certificates, trust accounts, and credit union accounts | most recent bank book or bank statements showing bank account balances |
| Individual Retirement Accounts, Keogh plans, pension funds, and annuities | written statement from an employer or financial institution attesting to the amount of current available funds |
| Securities including: stocks, bonds, options, futures contracts, money market and mutual funds, promissory notes, and savings bonds | written statement from the individual, corporation, licensed stockbroker, bank, or government agency issuing the security<br>*or*<br>written statement from a bank or other financial services institution able to verify the current value of a particular security |
| Life insurance policies | face and cash surrender values as indicated by the Table of Loan and Cash Surrender Value amounts located in the actual policy<br>*or*<br>current written statement from the issuing company or its representative indicating cash surrender value |
| Real estate | most recent tax bill indicating the tax assessment value<br>*or*<br>most recent property tax assessment issued by the taxing jurisdiction<br>*or*<br>current written appraisal performed by a licensed real estate agent or appraiser<br><br>*(less any outstanding loans)* |

## ASSET VERIFICATION (CONTINUED)

| Asset | Documentation |
|---|---|
| Motor vehicles | wholesale and finance value tables listed in the most recent valuation book<br>*or*<br>the "w" value in the older car valuation book<br>*or*<br>current written appraisal value from a licensed classic, custom made, or antique vehicle dealer<br><br>*(less any outstanding loans)* |
| Recreational vehicles<br>(including but not limited to):<br>Motorcycles<br>Boats<br>Motor homes | projected loan value quoted by a bank or other lending institution<br>*or*<br>current written estimate of cash value from a licensed recreational dealer<br><br>*(less any outstanding loans)* |

# APPENDIX C: SAMPLE DECISION LETTERS

This section contains a number of sample free care determination letters, which providers may use as models for their own letters. While providers do have some flexibility in deciding what they wish to include in these letters, certain elements in the letters are required by 114.6 CMR 10.08(3). If you edit the models, be sure not to delete any of the required elements.

Sample letters 1 through 10 are standard letters. Note that the partial free care and medical hardship letters assume that the provider requires a 20% deposit (up to $500 for partial free care patients or up to $1000 for medical hardship patients) for non-emergent services. If your facility's policy on the percentage required differs (note that the required deposit cannot be higher than 20% of the deductible or contribution amount), simply edit the percentage. If your facility does not charge pretreatment deposits, simply delete this section of the letter and the phrase this "deposit or" from the first sentence of the fourth paragraph.

Sample letters 11 through 17 are the letters that will be part of the electronic application that will be introduced next year. Because it is not possible to edit the text in the body of the letter, we have included sections in the header and footer that will allow you to include specific contact information, information on any required deposits, and other details. Note that these are only a limited subset of the letters that you will need, so it will continue to be necessary for you to generate some letters manually.

We hope that these sample letters are useful. If you have any questions, please contact the Division at 617-988-3222.

**Sample 1:** Full Free Care - Massachusetts Resident

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for free care.

You are eligible for full free care at <Provider> from <Date> to <Date>. Free care pays for the cost of medically necessary, non-experimental inpatient and outpatient services billed by <Provider>. It does not pay for experimental treatments, private room differential, or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

If you still need medical services when your free care eligibility period ends, you may reapply for free care by contacting the Patient Accounts Office at <Phone Number>. You must notify <Provider> if there are any changes to your family status during your free care eligibility period, such as changes in your family size, income, or health insurance coverage.

If you have any questions about this decision or your eligibility period, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. For information about filing a grievance, you may contact the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116, or you may call the Division at (617) 988-3222.

Sincerely,

**Sample 2:** Full Free Care - Non-Resident

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for free care.

You are eligible for full free care for emergent and urgent services only at <Provider> for the services you received on <Date>. Free care for emergent and urgent services pays for the cost of medically necessary, non-experimental emergency and urgent services billed by <Provider> for non-Massachusetts residents whose family income is below 200% of the Federal Poverty Income Guidelines. It does not pay for experimental treatments, private room differential, or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

If you receive emergent or urgent care services at <Provider> again, contact the Patient Accounts Office at <Phone Number> to see if you are still eligible for free care.

If you have any questions about this decision, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. For information about filing a grievance, you may contact the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116, or you may call the Division at (617) 988-3222.

Sincerely,

**Sample 3:** Hospital Partial Free Care - Massachusetts Resident

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Hospital> reviewed your application for free care.

You are eligible for partial free care at <Provider> from <Date> to <Date>. You have a deductible of <$$$$>, which is based on your income of <$$$$>. Once you have incurred medical bills totaling <$$$$>, you will be eligible for full free care for the remainder of your eligibility period. If you are approved for free care at more than one provider, or if more than one member of your family is approved for free care, you must keep track of your medical bills and notify the hospital when they reach <$$$$>. Free care pays for medically necessary, non-experimental inpatient and outpatient services billed by <Hospital>. It does not pay for experimental treatments, private room differential, or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

<Hospital> charges a deposit of 20% of the deductible amount up to $500 for non-emergent services. Because your deductible is <$$$$>, your deposit is <$$$$>. For the remaining deductible balance, <Hospital> offers a payment plan. The billing department will contact you concerning this deposit and a payment plan for your deductible balance.

If you have other medical bills that would prevent you from paying this deposit or deductible, you may apply for medical hardship. Medical hardship helps patients whose income and assets are insufficient to cover the cost of medically necessary care due to outstanding medical bills. Please call <Patient Account Representative> at <Phone Number> to apply for medical hardship.

If you still need medical services when your free care eligibility period ends, you may reapply for free care by contacting the Patient Accounts Office at <Phone Number>. You must notify <Hospital> if there are any changes to your family status during your free care eligibility period, such as changes in your family size, income, or health insurance coverage.

If you have any questions about this decision, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

**Sample 4:** CHC Partial Free Care - Resident

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Community Health Center> reviewed your application for free care.

You are eligible for partial free care at <Community Health Center> from <Date> to <Date>. You have a deductible of <$$$$>, which is based on your income of <$$$$>. You will be responsible for <%%%> of the costs of all medically necessary services you receive at <Community Health Center> until you meet your deductible. Once you have incurred medical bills totaling <$$$$>, you will be eligible for full free care for the remainder of your eligibility period. If you are approved for free care at more than one provider, or if more than one member of your family is approved for free care, you must keep track of your medical bills and notify the community health center when they reach <$$$$>. Free care pays for medically necessary, non-experimental inpatient and outpatient services billed by <Community Health Center>. It does not pay for experimental treatments, private room differential, or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

<Community Health Center > charges a deposit of 20% of the deductible amount up to $500 for non-emergent services. Because your deductible is <$$$$>, your deposit is <$$$$>. For the remaining deductible balance, <Community Health Center > offers a payment plan. The billing department will contact you concerning this deposit and a payment plan for your deductible balance.

If you have other medical bills that prevent you from paying this deposit or deductible, you may apply for medical hardship. Medical hardship helps patients whose income and assets are insufficient to cover the cost of medically necessary care due to outstanding medical bills. Please call <Patient Account Representative> at <Phone Number> to apply for medical hardship.

If you still need medical services when your Free Care eligibility period ends, you may reapply for free care by contacting the Patient Accounts Office at <Phone Number>. You must notify <Community Health Center> if there are any changes to your family status during your free care eligibility period, such as changes in your family size, income, or health insurance coverage.

If you have any questions about this decision, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

**Sample 5:** Hospital Partial Free Care – Non- Resident

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Hospital> reviewed your application for free care.

You are eligible for partial free care for emergent and urgent services only at <Hospital> for the cost of the emergent services you received on <Date>. You have a deductible of <$$$$>, which is based on your income of <$$$$>. Once you have incurred medical bills totaling <$$$$>, you will be eligible for full free care. If you are approved for free care at more than one provider, or if more than one member of your family is approved for free care, you must keep track of your medical bills and notify the hospital when they reach <$$$$>. Free care for emergent and urgent services only pays for medically necessary, non-experimental emergency and urgent services billed by <Hospital> for non-Massachusetts residents. It does not pay for experimental treatments, private room differential, or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

<Hospital> charges a deposit of 20% of the deductible amount up to $500 for non-emergent services. Because your deductible is <$$$$>, your deposit is <$$$$>. For the remaining deductible balance, <Hospital> offers a payment plan. The billing department will contact you concerning this deposit and a payment plan for your deductible balance.

If you have other medical bills that would prevent you from paying this deposit or deductible, you may apply for medical hardship. Medical hardship helps patients whose income and assets are insufficient to cover the cost of medically necessary care due to outstanding medical bills. Please call <Patient Account Representative> at <Phone Number> to apply for medical hardship.

If you receive emergent or urgent care services at <Hospital> again, contact the Patient Accounts Office at <Phone Number> to see if you are still eligible for free care.

If you have any questions about this decision, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

**Sample 6:** Community Health Center Partial Free Care - Non-Resident

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Community Health Center> reviewed your application for free care.

You are eligible for partial free care for emergent and urgent services only at <Community Health Center>, which pays for the cost of the emergent and urgent care services you received on <Date>. You have a deductible of <$$$$>, which is based on your income of <$$$$>. You are responsible for <%%%> of the costs of all medically necessary services you receive at <Community Health Center> until you meet your deductible. Once you have incurred medical bills totaling <$$$$>, you will be eligible for full free care. If you are approved for free care at more than one provider, or if more than one member of your family is approved for free care, you must keep track of your medical bills and notify the community health center when they reach <$$$$>. Free care for emergent and urgent services only pays for medically necessary, non-experimental emergency and urgent services billed by <Community Health Center> for non-Massachusetts residents. It does not pay for experimental treatments or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

If you receive emergent or urgent care services at <Community Health Center> again, contact the Patient Accounts Office at <Phone Number> to see if you are still eligible for free care.

<Community Health Center> charges a deposit of 20% of the deductible amount up to $500 for non-emergent services. Because your deductible is <$$$$>, your deposit is <$$$$>. For the remaining deductible balance, <Hospital> offers a payment plan. The billing department will contact you concerning this deposit and a payment plan for your deductible balance.

If you have other medical bills that prevent you from paying this deductible, you may apply for medical hardship. Medical hardship helps patients whose income and assets are insufficient to cover the cost of medically necessary care due to outstanding medical bills. Please call <Patient Account Representative> at <Phone Number> to apply for medical hardship.

If you have any questions about this decision, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

**Sample 7:** Free Care due to Medical Hardship - Massachusetts Resident

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for medical hardship.

You are eligible for medical hardship assistance at <Provider> from <Date> to <Date>. You reported medical bills totaling <$$$$>. Your medical hardship contribution is <$$$$> (see calculation below). This is the amount you must contribute towards your medical expenses. You are eligible for full free care for all medically necessary services you receive at <Provider> above this medical hardship contribution for the remainder of your eligibility period. Free care pays for medically necessary, non-experimental inpatient and outpatient services billed by <Provider>. It does not pay for experimental treatments, private room differential, or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

<Provider> charges a deposit of 20% of the medical hardship contribution amount up to $1,000 for non-emergent services. Because your contribution is <$$$$>, your deposit is <$$$$>. For the remaining deductible balance, <Provider> offers a two year payment plan. The billing department will contact you concerning this deposit and a payment plan for your deductible balance.

If you still need medical services when your eligibility period ends, you may reapply for free care by contacting the Patient Accounts Office at <Phone Number>. You must notify <Hospital> if there are any changes to your family status during your free care eligibility period, such as changes in your family size, income, or health insurance coverage.

If you have any questions about this decision, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

**Calculation:**
Family income: <$$$$>
30% of family income: <$$$$>
Available assets: <$$$$>
Medical hardship contribution = <$$$$> + <$$$$> = **<$$$$>**

**Sample 8:** Free Care due to Medical Hardship - Non-Resident

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for medical hardship.

You are eligible for medical hardship assistance for emergent and urgent services only at <Provider>. Your eligibility applies to the emergent and urgent care services you received on <Date>. You reported medical bills totaling <$$$$>. Your medical hardship contribution is <$$$$> (see calculation below). This is the amount you must contribute towards your medical expenses. You are eligible for full free care for emergent and urgent medically necessary services you receive at <Provider> above this medical hardship contribution. Free care for emergent and urgent services only covers medically necessary, non-experimental inpatient and outpatient services billed by <Provider> for non-Massachusetts residents. It does not cover experimental treatments, private room differential, or other non-medically necessary services. It also does not cover the cost of services billed by other independent groups, such as private physicians and specialty care groups.

<Provider> charges a deposit of 20% of the medical hardship contribution amount up to $1,000 for non-emergent services. Because your contribution is <$$$$>, your deposit is <$$$$>. For the remaining contribution balance, <Provider> offers a payment plan. The billing department will contact you concerning this deposit and a payment plan for your contribution balance.

If you receive emergent or urgent care services at <Provider> again, contact the Patient Accounts Office at <Phone Number> to see if you are still eligible for free care.

If you have any questions about this decision, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

**Calculation:**
Family income: <$$$$>
30% of family income: <$$$$>
Available assets: <$$$$>
Medical hardship contribution = <$$$$> + <$$$$> = **<$$$$>**

**Sample 9:** Incomplete Application – Missing Documentation

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for free care.

_____ We are unable to process your application because you did not supply the required income documentation. Acceptable income documentation includes the following:

*Wages*

Two weeks' worth of recent pay stubs
Affidavit from employer stating gross income
Copy of signed employment contract
W-2 forms
Most recent income tax return

*Child Support, Alimony, or Personal Needs Allowance for a family member in a nursing home*

Court payment records or court order indicating payment amount
Copies of canceled checks or money orders

*Social Security or other benefits*

Most recent benefit award letter, benefit statements, or check stubs

*Other Income*

If you have other income, such as pension income or rental income, that is not on this list, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. for assistance.

_____ We are unable to process your application because you did not supply the required residency documentation. Acceptable residency documentation includes the following:

Driver's License, Utility Bill, Paycheck Stub, Unemployment Benefit Stub, Social Security Check Stub, State Income Tax Form, Federal Income Tax Form, Passport, Alien Registry Card, Voter ID Card, Welfare or Insurance Plan Card, Travel Visa

**Please submit this information as soon as possible. We cannot process your application without this information.** If you cannot supply the required documentation, or if you have any questions, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m.

Sincerely,

**Sample 10:** Denial of Free Care

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for free care.

_____You are ineligible for free care at <Provider> because your family income of <$$$$> is too high. If you have other medical bills that prevent you from paying your hospital bill, you may wish to apply for medical hardship. Medical hardship helps patients whose income and assets are insufficient to cover the costs of medically necessary care due to outstanding medical bills. Please call <Patient Account Representative> at <Phone Number> to complete a medical hardship supplement to your free care application.

_____You are ineligible for free care at <Provider> because you are not a Massachusetts resident and you applied for free care coverage of non-emergent or non-urgent medical services. Free care pays for the cost of emergent or urgent medical services only for non-Massachusetts residents. If you receive emergent or urgent services at <Provider>, contact the Patient Accounts Office at <Phone Number> to see if you are eligible for free care.

If you have any questions about this decision, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

**Sample 11 (Electronic Application Version):** Resident Full Free Care Approval

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for free care.

You are eligible for full free care at <Provider> from <Date> to <Date>. Free care pays for the cost of medically necessary, non-experimental inpatient and outpatient services billed by <Provider>. It does not pay for experimental treatments, private room differential, or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

If you still need medical services when your free care eligibility period ends, you may reapply for free care by contacting <Provider>. You must notify <Provider> if there are any changes to your family status during your free care eligibility period, such as changes in your family size, income, or health insurance coverage.

If you have any questions about this decision or your eligibility period, please contact <Provider>. If you need to file a grievance, you may contact the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116, or you may call the Division at (617) 988-3222.

Sincerely,

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Footer Information:

Please call <Patient Accounts Representative> at <Telephone Number> with any questions.

**Sample 12 (Electronic Application Version):** Non-resident Full Free Care Approval

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for free care.

You are eligible for full free care for emergent and urgent services only at <Provider>. Free care for emergent and urgent services pays for the cost of medically necessary, non-experimental emergency and urgent services billed by <Provider> for non-Massachusetts residents whose family income is below 200% of the Federal Poverty Income Guidelines. It does not pay for experimental treatments, private room differential, or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

If you receive emergent or urgent care services at <Provider> again, contact <Provider> to see if you are still eligible for free care.

If you have any questions about this decision, please contact <Provider>. For information about filing a grievance, you may contact the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116, or you may call the Division at (617) 988-3222.

Sincerely,

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Footer Information:

Eligibility Dates:
Please call <Patient Accounts Representative> at <Telephone Number> with any questions.

**Sample 13 (Electronic Application Version):** Resident Partial Free Care Approval – Deposit Required

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for free care.

You are eligible for partial free care at <Provider> from <Date> to <Date>. You have a deductible of <$$$$>, which is based on your income of <$$$$>. Once you have incurred medical bills totaling <$$$$>, you will be eligible for full free care for the remainder of your eligibility period. If you are approved for free care at more than one provider, or if more than one member of your family is approved for free care, you must keep track of your medical bills and notify the hospital when they reach <$$$$>.

Free care pays for medically necessary, non-experimental inpatient and outpatient services billed by <Provider>. It does not pay for experimental treatments, private room differential, or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

<Provider> charges a deposit for non-emergent services. <Provider> also offers a payment plan for any remaining deductible balance. The billing department will contact you concerning this deposit and a payment plan. If you have other medical bills that would prevent you from paying this deposit or deductible, you may apply for Medical Hardship. Medical Hardship helps patients whose income and assets are insufficient to cover the cost of medically necessary care due to outstanding medical bills. Please call <Provider> if you would like to apply for Medical Hardship.

If you still need medical services when your free care eligibility period ends, you may reapply for free care by contacting <Provider>. You must notify <Provider> if there are any changes to your family status during your free care eligibility period, such as changes in your family size, income, or health insurance coverage.

If you have any questions about this decision, please contact <Provider>. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

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Footer Information:

Please call <Patient Accounts Representative> at <Telephone Number> with any questions or to request a Medical Hardship application.

**Sample 14 (Electronic Application Version):** Resident Partial Free Care Approval – No Deposit Required

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for free fare.

You are eligible for partial free care at <Provider> from <Date> to <Date>. You have a deductible of <$$$$>, which is based on your income of <$$$$>. Once you have incurred medical bills totaling <$$$$>, you will be eligible for full free care for the remainder of your eligibility period. If you are approved for free care at more than one provider, or if more than one member of your family is approved for free care, you must keep track of your medical bills and notify the hospital when they reach <$$$$>.

Free care pays for medically necessary, non-experimental inpatient and outpatient services billed by <Provider>. It does not pay for experimental treatments, private room differential, or other non-medically necessary services. It also does not pay for the cost of services billed by other independent groups, such as private physicians and specialty care groups.

<Provider> offers a payment plan for your deductible balance. The billing department will contact you to arrange a payment plan. If you have other medical bills that would prevent you from paying this deposit or deductible, you may apply for Medical Hardship. Medical Hardship helps patients whose income and assets are insufficient to cover the cost of medically necessary care due to outstanding medical bills. Please call <Provider> if you would like to apply for Medical Hardship.

If you still need medical services when your free care eligibility period ends, you may reapply for free care by contacting <Provider>. You must notify <Provider> if there are any changes to your family status during your Free Care eligibility period, such as changes in your family size, income, or health insurance coverage.

If you have any questions about this decision, please contact <Provider>. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

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Footer Information:

Please call <Patient Accounts Representative> at <Telephone Number> with any questions or to request a Medical Hardship application.

**Sample 15 (Electronic Application Version):** Incomplete Application – Missing Documentation

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for Free Care.

_____ We are unable to process your application because you did not supply the required income documentation. Acceptable income documentation includes the following:

*Wages*

Two weeks' worth of recent pay stubs
Affidavit from employer stating gross income
Copy of signed employment contract
W-2 forms
Most recent income tax return

*Child Support, Alimony, or Personal Needs Allowance for a family member in a nursing home*

Court payment records or court order indicating payment amount
Copies of canceled checks or money orders

*Social Security or other benefits*

Most recent benefit award letter, benefit statements, or check stubs

*Other Income*

If you have other income, such as pension income or rental income, that is not on this list, please contact <Patient Account Representative> at <Phone Number>, Monday through Friday, 8:30 a.m. - 4:30 p.m. for assistance.

_____ We are unable to process your application because you did not supply the required residency documentation. Acceptable residency documentation includes the following:

Driver's License, Utility Bill, Paycheck Stub, Unemployment Benefit Stub, Social Security Check Stub, State Income Tax Form, Federal Income Tax Form, Passport, Alien Registry Card, Voter ID Card, Welfare or Insurance Plan Card, Travel Visa

Please submit this information as soon as possible. **We cannot process your application without this information. If you cannot supply the required documentation, or if you have any questions, please contact the person listed below for acceptable alternatives.**

Sincerely,

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Footer Information:

Please call <Patient Accounts Representative> at <Telephone Number> with any questions.

**Sample 16 (Electronic Application Version):** Resident Free Care Denial (over income)

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for free care.

You are ineligible for free care at <Provider> because your family income of <$$$$> is too high. If you have other medical bills that prevent you from paying your hospital bill, you may wish to apply for Medical Hardship. Medical Hardship helps patients whose income and assets are insufficient to cover the costs of medically necessary care due to outstanding medical bills. Please call <Provider> at the number listed below to complete a Medical Hardship supplement to your free care application.

If you have any questions about this decision, please contact <Provider>. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

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Footer Information:

Please call <Patient Accounts Representative> at <Telephone Number> with any questions or to request a Medical Hardship supplement.

**Sample 17 (Electronic Application Version):** Non-resident, Non-emergent Free Care Denial

<Date>

<Applicant>
<Address>
<City, State, Zip>

Dear <Applicant>:

<Provider> reviewed your application for free care.

You are ineligible for free care for the non-emergent or non-urgent medical services you received because you are not a Massachusetts resident. Free care pays only the cost of emergent or urgent medical services for non-Massachusetts residents. If you do receive emergent or urgent care services at <Provider>, contact <Provider> at the number listed below to see if you are eligible for free care.

If you have any questions about this decision, please contact <Provider>. If you disagree with this decision, you may also file a written grievance with the Massachusetts Division of Health Care Finance and Policy, Free Care Appeals, Two Boylston Street, Boston, MA 02116. For more information on filing a grievance, you may call the Division at (617) 988-3222.

Sincerely,

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Footer Information:

Please call <Patient Accounts Representative> at <Telephone Number> with any questions.

## APPENDIX D: 1999 FEDERAL POVERTY INCOME GUIDELINES

**EFFECTIVE MARCH 18, 1999**

| Family Size | 200% | 250% | 300% | 350% | 400% |
|---|---|---|---|---|---|
| **1** | **$16,480** | $20,600 | $24,720 | $28,840 | **$32,960** |
| **2** | **$22,120** | $27,650 | $33,180 | $38,710 | **$44,240** |
| **3** | **$27,760** | $34,700 | $41,640 | $48,580 | **$55,520** |
| **4** | **$33,400** | $41,750 | $50,100 | $58,450 | **$66,800** |
| **5** | **$39,040** | $48,800 | $58,560 | $68,320 | **$78,080** |
| **6** | **$44,680** | $55,850 | $67,020 | $78,190 | **$89,360** |
| **7** | **$50,320** | $62,900 | $75,480 | $88,060 | **$100,640** |
| **8** | **$55,960** | $69,950 | $83,940 | $97,930 | **$111,920** |
| **Each additional person** | **Add $5,640** | Add $7,050 | Add $8,460 | Add $9,870 | **Add $11,280** |